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Health Care that Matters

Your Behavioral Health Screening Tools Pocket Reference

The role of health care professionals has evolved to include discussing and addressing mental health and substance use disorders with patients. In fact, the relationships that patients have with their doctors and other health care professionals have proven to be one of the most important factors in ensuring individuals receive appropriate behavioral health care.

Recognizing the signs of a behavioral health condition is not always easy. We are providing you with the following behavioral health screening tools to help you diagnose and refer individuals for further care. We hope you find this reference guide useful in determining the best treatment options.

TABLE OF CONTENTS

PHQ-2: QUESTIONS

Patient Health Questionnaire-2 (PHQ-2)				
Over the past 2 weeks, how often have you been bothered by any of the following problems?				
	Not At All	**Several Days**	**More Than Half The Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

PHQ-2: SCORING AND ACTION STEPS

Patient Health Questionnaire-2 (PHQ-2)	
Scoring	**Action Steps**
Score of 0-2 = Negative Screen	**Action:** None
Score of 3+ = Positive Screen	**Action:** Administer the PHQ-9.

PHQ-9: QUESTIONS

Patient Health Questionnaire-9 (PHQ-9) **Over the last 2 weeks, how often have you been bothered by any of the following problems?**				
	Not At All	**Several Days**	**More Than Half The Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
* If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

PHQ-9: SCORING AND ACTION STEPS

Patient Health Questionnaire-9 (PHQ-9)	
Scoring	**Action Steps**
Score of 1-4 = Minimal depression	**Action:** Watchful waiting; repeat PHQ-9 at follow-up visit.
Score of 5-9 = Mild depression	**Action:** Watchful waiting; repeat PHQ-9 at follow-up visit. Possible referral to behavioral health care professional for psychotherapy within 30 days of positive screen.
Score of 10-14 = Moderate depression	**Action:** Develop treatment plan, consider pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen.
Score of 15-19 = Moderately severe depression	**Action:** Active treatment with pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen.
Score of 20-27 = Severe depression	**Action:** Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.
Positive score on Item 9	**Action:** Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.

PHQ-9 MODIFIED FOR TEENS: QUESTIONS

Patient Health Questionnaire-9 (PHQ-9) Modified for Teens				
Over the past 2 weeks, how often have you been bothered by any of the following problems?				
	Not At All	**Several Days**	**More Than Half The Days**	**Nearly Every Day**
1. Feeling down, depressed, irratable, or hopeless?	0	1	2	3
2. Little interest or pleasure in doing things?	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
4. Poor appetite, weight loss, or overeating?	0	1	2	3
5. Feeling tired, or having little energy?	0	1	2	3
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things like school work, reading, or watching tv?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3
In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes?			Yes	No
*If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
Has there been a time in the **past month** when you have had serious thoughts about ending your life?			Yes	No
Have you ***ever***, in your ***whole life,*** tried to kill yourself or made a suicide attempt?			Yes	No

PHQ-9 MODIFIED FOR TEENS: SCORING AND ACTION STEPS

Patient Health Questionnaire-9 (PHQ-9) Modified for Teens	
Scoring	**Action Steps**
Score of 1-4 = Minimal depression	**Action:** Watchful waiting; repeat PHQ-9 at follow-up visit.
Score of 5-9 = Mild depression	**Action:** Watchful waiting; repeat PHQ-9 at follow-up visit. Possible referral to behavioral health care professional for psychotherapy within 30 days of positive screen.
Score of 10-14 = Moderate depression	**Action:** Develop treatment plan, consider pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen.
Score of 15-19 = Moderately severe depression	**Action:** Active treatment with pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen.
Score of 20-27 = Severe depression	**Action:** Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to a behavioral health care professional for psychotherapy and/or collaborative management.
Positive score on Item 9	**Action:** Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.

EPDS: QUESTIONS

Edinburgh Postnatal Depression Scale (EPDS)				
Please answer the following questions with how you have felt IN THE PAST SEVEN DAYS, not just how you feel today.				
1. I have been able to laugh and see the funny side of things	0	1	2	3
	As much as I always could	Not quite so much now	Definitely not so much now	Not at all
2. I have looked forward with enjoyment to things	0	1	2	3
	As much as I ever did	Rather less than I used to	Definitely less than I used to	Hardly at all
3. I have blamed myself unnecessarily when things went wrong	3	2	1	0
	Yes, most of the time	Yes, some of the time	Not very often	No, never
4. I have been anxious or worried for no good reason	0	1	2	3
	No, not at all	Hardly ever	Yes, sometimes	Yes, very often
5. I have felt scared or panicky for no very good reason	3	2	1	0
	Yes, quite a lot	Yes, sometimes	No, not much	No, not at all
6. Things have been getting to me	3	2	1	0
	Yes, most of the time I haven't been able to cope at all	Yes, sometimes I haven't been coping as well as usual	No, most of the time I have coped quite well	No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping	3	2	1	0
	Yes, most of the time	Yes, sometimes	Not very often	No, not at all
8. I have felt sad or miserable	3	2	1	0
	Yes, most of the time	Yes, quite often	Not very often	No, not at all

EPDS: QUESTIONS (CONTINUED)

Edinburgh Postnatal Depression Scale (EPDS)				
9. I have been so unhappy that I have been crying	3	2	1	0
	Yes, most of the time	Yes, quite often	Only occasionally	No, never
10. The thought of harming myself has occurred to me	3	2	1	0
	Yes, quite often	Sometimes	Hardly ever	Never

EPDS: SCORING AND ACTION STEPS

Edinburgh Postnatal Depression Scale (EPDS)	
Scoring	**Action Steps**
Score of 0-9 = Low probability of depression	**Action:** Watchful waiting; repeat EPDS at follow-up visit.
Score of 10-30 = High probability of moderate to severe depression	**Action:** Develop treatment plan, possible active treatment with pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen.
If a patient scores a 1, 2, or 3 on question 10, please address suicidal thoughts immediately	**Action:** Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.

GERIATRIC DEPRESSION SCALE (GDS) – SHORT FORM: QUESTIONS

Geriatric Depression Scale (GDS) - Short Form		
Give the answer which best describes how you have felt over the past week.		
1. Are you basically satisfied with your life?	Yes	**No**
2. Have you dropped many of your activities and interests?	**Yes**	No
3. Do you feel that your life is empty?	**Yes**	No
4. Do you often get bored?	**Yes**	No
5. Are you in good spirits most of the time?	Yes	**No**
6. Are you afraid that something bad is going to happen to you?	**Yes**	No
7. Do you feel happy most of the time?	Yes	**No**
8. Do you often feel helpless?	**Yes**	No
9. Do you prefer to stay at home, rather than going out and doing things?	**Yes**	No
10. Do you feel that you have more problems with memory than most?	**Yes**	No
11. Do you think it is wonderful to be alive now?	Yes	**No**
12. Do you feel worthless the way you are now?	**Yes**	No
13. Do you feel full of energy?	Yes	**No**
14. Do you feel that your situation is hopeless?	**Yes**	No
15. Do you think that most people are better off than you are?	**Yes**	No

GERIATRIC DEPRESSION SCALE (GDS) – SHORT FORM: SCORING AND ACTION STEPS

Geriatric Depression Scale (GDS) - Short Form	
Score 1 point for each bolded answer.	
Scoring	**Action Steps**
Score of 1-4 = Minimal depression	**Action:** Watchful waiting; repeat GDS at follow-up visit.
Score of 5-15 = Mild to severe depression	**Action:** Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.

GAD-2: QUESTIONS

Generalized Anxiety Disorder Scale-2 (GAD-2)				
Over the last 2 weeks, how often have you been bothered by the following problems?				
	Not At All	**Several Days**	**More Than Half The Days**	**Nearly Every Day**
1. Feeling, nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3

GAD-2: SCORING AND ACTION STEPS

Generalized Anxiety Disorder Scale-2 (GAD-2)	
Scoring	**Action Steps**
Score of 0-2 = Negative Screen	**Action:** None
Score of 3+ = Positive Screen	**Action:** Administer the GAD-7.

GAD-7: QUESTIONS

Generalized Anxiety Disorder Scale-7 (GAD-7)				
Over the last 2 weeks, how often have you been bothered by the following problems?				
	Not At All	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

GAD-7: SCORING AND ACTION STEPS

Generalized Anxiety Disorder Scale-7 (GAD-7)	
Scoring	**Action Steps**
Score of 1-4 = Minimal anxiety	**Action:** Watchful waiting; repeat GAD-7 at follow-up visit.
Score of 5-9 = Mild anxiety	**Action:** Watchful waiting; repeat GAD-7 at follow-up visit.
Score of 10-14 = Moderate anxiety	**Action:** Further diagnostic assessment by PCP or behavioral health care professional. Consider pharmacotherapy and/or psychotherapy.
Score of 15-21 = Severe anxiety	**Action:** Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to a behavioral health care professional for psychotherapy and/or collaborative management.

NIDA-QUICK SCREEN: QUESTIONS

National Institute on Drug Abuse (NIDA) – Quick Screen					
In the past year, how often have you used the following?					
	Never	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
1. Alcohol (For men, 5 or more drinks a day. For women, 4 or more drinks a day.)*					
2. Tobacco Products					
3. Prescription Drugs for Non-Medical Reasons					
4. Illegal Drugs					

*Single question alcohol screener

NIDA-QUICK SCREEN: SCORING AND ACTION STEPS

National Institute on Drug Abuse (NIDA) – Quick Screen	
Scoring	**Action Steps**
If respondent indicates "No" for all drugs in prescreen	**Action:** Reinforce abstinence.
If respondent indicates "Yes" to any of the drugs listed	**Action:** Review current list of medications to ensure medications prescribed are not at risk for abuse. Provide brief counseling (5-15 minutes) to help the patient develop a plan to reduce drinking, identify high-risk situations, and learn coping strategies. Consider referral to behavioral health care professional within 60 days of positive screen.

AUDIT-C: QUESTIONS

Alcohol Use Disorders Identification Test - Consumption (AUDIT-C)					
	A	**B**	**C**	**D**	**E**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
2. How many standard drinks containing alcohol do you have on a typical day?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

AUDIT-C: SCORING AND ACTION STEPS

Alcohol Use Disorders Identification Test - Consumption (AUDIT-C)	
Standard Drink: 1 drink=12 oz. beer or cooler, 8 to 9 oz. malt liquor, 5 oz. table wine, 1.5 oz. 80-proof hard liquor.	
A=0 points B=1 point C=2 points D=3 points E=4 points	
Scoring	**Action Steps**
Score of 0-3 in Men = Minimal to moderate use. Low probability of abuse or dependence. **Score of 0-2 in Women** = Minimal to moderate use. Low probability of abuse or dependence.	**Action:** Reinforce abstinence. Watchful waiting; repeat AUDIT-C at follow-up visit.
Score of 4-12 in Men = Moderate to severe use. High probability of abuse or dependence. **Score of 3-12 in Women** = Moderate to severe use. High probability of abuse or dependence.	**Action:** Review current list of medications to ensure medications prescribed are not at risk for abuse. Provide brief counseling (5-15 minutes) to help the patient develop a plan to reduce drinking, identify high-risk situations, and learn coping strategies. Consider referral to behavioral health care professional within 60 days of positive screen.

AUDIT: QUESTIONS

Alcohol Use Disorders Identification Test (AUDIT)					
During the past year	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink containing alcohol?	Never (Skip to Qs 9 &10)	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion? (Skip to Qs 9 & 10 if Total Score for Qs 2 & 3 = 0)	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

AUDIT: QUESTIONS (CONTINUED)

Alcohol Use Disorders Identification Test (AUDIT)					
9. Have you or someone else been injured as a result of your drinking?	No	---	Yes, but not in the last year	---	Yes, during the last year
10. Has a relative, friend, doctor, or another health worker been concerned about your drinking or suggested you cut down?	No	---	Yes, but not in the last year	---	Yes, during the last year

AUDIT: SCORING AND ACTION STEPS

Alcohol Use Disorders Identification Test (AUDIT)	
Standard Drink: 1 drink=12 oz. beer or cooler, 8 to 9 oz. malt liquor, 5 oz. table wine, 1.5 oz. 80-proof hard liquor.	
Scoring	**Action Steps**
Score of 1-7 = Minimal to moderate use. Low probability of abuse or dependence.	**Action:** Reinforce abstinence. Watchful waiting; repeat AUDIT at follow-up visit.
Score of 8-15 = Moderate to severe use. Moderate probability of abuse or dependence. **Score of 16-19** = Moderate to severe use. Moderate to high probability of abuse or dependence. **Score of 20-40** = Severe use. High probability of abuse or dependence.	Review current list of medications to ensure medications prescribed are not at risk for abuse. Provide brief counseling (5-15 minutes) to help the patient develop a plan to reduce drinking, identify high-risk situations, and learn coping strategies. Consider referral to behavioral health care professional within 60 days of positive screen.

C-SSRS: QUESTIONS

Columbia – Suicide Severity Rating Scale (C-SSRS) – Screen Version – Recent		
Suicide Ideation Definitions and Prompts	**Past Month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* e.g., "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it….and I would never go through with it."		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to *"I have the thoughts but I definitely will not do anything about them."*		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

C-SSRS: QUESTIONS (CONTINUED)

Columbia – Suicide Severity Rating Scale (C-SSRS) – Screen Version – Recent		
Suicide Ideation Definitions and Prompts	**Past Month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *Was this within the past three months?***		

C-SSRS: SCORING AND ACTION STEPS

Columbia – Suicide Severity Rating Scale (C-SSRS) – Screen Version – Recent	
Scoring	**Action Steps**
1 or more "Yes" responses are a positive screen.	**Action:** Refer to behavioral health care professional to evaluate risk factors and determine appropriate treatment setting.
A "Yes" response on questions #4 or #5 in the past month or any behavior in question #6 is an indicator of severe risk.	**Action:** Refer to behavioral health care professional to evaluate for hospitalization.

Please consult with the following resources for help in making referrals or determining treatment options for your EmblemHealth patients:

EmblemHealth Behavioral Health Services Program:
888-447-2526

Beacon Health Options PCP Consult Line/Psychiatric Hotline:
877-241-5575 (Routine Consultations)

Beacon Health Options Referral/Scheduling:
877-695-9449 (Routine/Urgent Consultations)

University Behavioral Associates Referral Line
800-401-4822 (Montefiore only)

Beacon Health Options PCP Toolkit:
providertoolkit.beaconhealthoptions.com

Community Resources

NYC Well-Hotline:
888-NYC-WELL (888-692-9355)

National Suicide Prevention Hotline:
800-273-8255

References

PHQ-2, PHQ-9, GAD-2, GAD-7: Spitzer, R.; Williams, J. B.W.; Kroenke, K. and colleagues, with an educational grant from Pfizer. No permission required to reproduce, translate, display, or distribute.

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GDS: Yes average: The Use of Rating Depression Series in the Elderly, in Poon (ed.): Clinical Memory Assessment of Older Adults, American Psychological Association, 1986.

NIDA-Quick Screen: National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services.

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AUDIT: Babor, T.F.; de la Fuente, J.R.; Saunders, J.; and Grant, M. AUDIT. *The Alcohol Use Disorders Identification Test. Guidelines for use in primary health care*. Geneva, Switzerland: World Health Organization, 1992.

C-SSRS: Developed by Drs. Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

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